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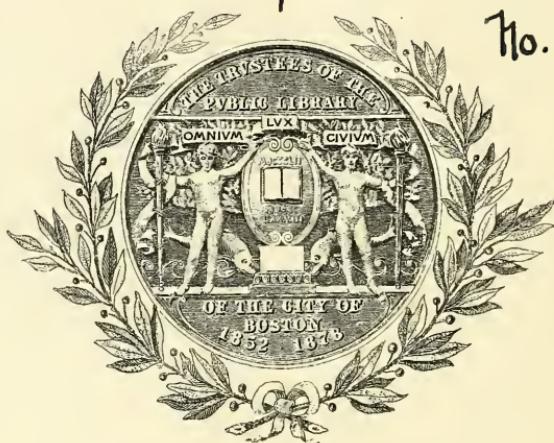


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Administrative Policies

Emergency Maternity and Infant Care Program

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U.S. Children's Bureau

EMIC Information Circular No. 1

December 1943



UNITED STATES DEPARTMENT OF LABOR

Frances Perkins, Secretary

CHILDREN'S BUREAU

Katharine F. Lenroot, Chief

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Administrative Policies

Emergency Maternity and Infant Care Program

The following statement of administrative policies, as revised in December 1943, has been prepared by the Children's Bureau for the information of the State health agencies administering emergency maternity and infant care programs and of individuals or other agencies concerned with the provision of services under this program. ***This statement of policies will supersede MCH Information Circular No. 13 and all other EMIC policy memoranda.***

The Children's Bureau will use these policies as the basis for approval of the related portions of State emergency maternity and infant care plans for the fiscal year 1945, and of revisions, amendments, or supplements to emergency maternity and infant care plans received during the remainder of the fiscal year 1944. State health agencies may amend their emergency maternity and infant care plans now or at any time during the current fiscal year in accordance with these revised policies.

The administrative policies of the Children's Bureau have been developed within the framework of the Congressional acts and the regulations of the Secretary of Labor, and in accordance with the intent of Congress as shown by the legislative history and as interpreted by the Bureau and by the Solicitor of the Department of Labor. In the light of the experience of the State health agencies and with the advice of the Bureau's professional advisory committees, many modifications of policy have been made. Recommendations made at the conference of official representatives of the servicemen and of medical organizations, held at the Children's Bureau on December 10 and 11, 1943, have been considered carefully in reaching decisions as to these policies. A supplemental statement of policy will be issued on health supervision of infants after further conferences with administrative agencies (see Note, p. 12), and, as experience indicates, on other subjects.

I. Individuals for Whom EMIC Services May Be Authorized.

1. Any woman applying for care whose husband, at the time of initial application, was in the 4th, 5th, 6th, or 7th pay grade of the United States Army, Navy, Marine Corps, or Coast Guard (including enlisted men in these grades who are deceased or missing in action).¹
2. Any infant under 1 year of age for whom an application is made whose father at the time of application was in the 4th, 5th, 6th, or 7th pay grade of the United States Army, Navy, Marine Corps, or Coast Guard (including men in these grades who are deceased or missing in action).¹

II. Conditions Under Which Services May Be Authorized.

1. The individual for whom services are authorized is the wife or infant of an enlisted man in the 4th, 5th, 6th, or 7th pay grade of the armed forces of the United States.
2. There shall be no financial investigation or means test to determine eligibility as a condition of receiving any service provided under the EMIC program.
3. Similar service is not readily available (without financial investigation and without cost to the patient) from the medical personnel or hospitals of the United States Army, Navy, Public Health Service, or from clinics or conferences or other services provided by or through State or local public-health agencies or services available under State crippled children's programs.
4. The wife of an enlisted man may have free choice under the program of all types of available facilities and services, including private practitioners, clinics, hospitals, and other health facilities that meet the standards established under a State plan for each type of service or facility.
5. The attending physician has the qualifications and the hospital meets the standards established under the State plan.
6. The attending physician or clinic has agreed to accept payment only from the State health agency for whatever medical or surgical services he renders during pregnancy, labor, and 6 weeks postpartum, or for the care of an infant, for which authorization has been issued under the State program. (See sec. IV for types of service that may be authorized.)

¹ If an enlisted man in one of the four lowest pay grades, for whose wife or infant application for care has been made, is discharged or promoted after the date of application, or if his wife or infant moves to another State or changes physicians, his wife or infant can continue to receive services available under the plan.

For purpose of eligibility, the date of application is the date when an application for care is received by the State or local health agency, whether on official forms or by letter or by telephone. If application was made by telephone, the date of application is the date when such application was made according to the records of the State or local health agency.

7. The hospital, if hospital care is requested, has agreed to accept payment only from the State health agency for services rendered during a period of authorized hospital care under the program, and will agree to provide at least 10 days' care following delivery if accommodations are available and if the patient wishes to remain in the hospital.
8. The hospital will provide whatever accommodations are indicated by the patient's medical condition at the per diem rate paid by the State health agency.
9. Physicians' services will not be authorized if the patient or someone in behalf of the patient is to pay for hospital care; and hospital care will not be authorized if the patient or someone in behalf of the patient is to pay the physician for medical care.
10. The cost of medical services in a clinic and/or hospital, including maintenance and salaries, where such medical service is provided by staff physicians (such as interns, resident staff, and attending physicians employed full time or part time by the clinic or hospital or other physicians supervising or assisting interns or resident physicians) must be included in the cost per clinic visit and the hospital cost per patient day, as outlined in the Children's Bureau memorandum of September 1, 1943, Purchase of Hospital Care Under Programs for Maternal and Child Health and Crippled Children.
11. Individuals accepted for care under the program will be referred routinely to local public-health agencies for the provision of public-health-nursing services that can be made available.
12. Arrangements will be made to utilize community facilities, including appropriate social and health agencies, to meet the needs of mothers and infants that cannot be provided under the EMIC program.

DISCUSSION

The emergency maternity and infant care program has been established to provide maternity and infant care to the wives and infants of enlisted men in the four lowest pay grades regardless of where they are living, through the development of an organized plan, under the jurisdiction of the State health agency, with a view to making the care provided under the Congressional act available and accessible to all wives who wish to apply for their own care or care of their infants.

The emergency maternity and infant care program is to supplement and not to replace existing facilities for care, which may be available without cost and without financial investigation to enlisted men's wives or infants.

The Congress has made it clear that the care is to be provided as a service to which the wife and infant of an enlisted man are entitled without financial investigation, and that the program is intended to provide the care, if requested by or for the wife or infant of any enlisted man in the four lowest pay grades, in order to relieve the enlisted man and his wife of any uncertainty as to how the cost of care will be met and to assure them that care will be provided.

The quality of care should be the best available. To help accomplish this the State health agencies must establish standards for the selection of physicians, nurses, hospitals, and clinics providing care, make available consultation services by specialists, and other special services, wherever available, and endeavor in every manner possible to maintain recognized high standards of care for mother and child. Quality of care implies that the fullest possible consideration be given to the needs of each patient and that all community resources be mobilized to meet social as well as medical needs.

In order to relieve the enlisted man and his wife of all anxiety with regard to how the cost of care will be met, the State agency, when authorizing medical or hospital care, assumes full responsibility for the payment for such services in accordance with the rates established under the program.

If a physician were to request authorization for hospital care under the program and arrange with the patient to pay him for her medical care, or if he were to request authorization for medical care when the patient is to pay for hospital care, or if a physician or hospital were to charge the patient an amount in addition to that paid by the State agency, it would nullify the Congressional objective of providing care without cost to the enlisted man or his family.

III. Application and Authorization for Care.

A. APPLICATION FOR CARE.²

1. **Maternity care:** Since the wife is entitled, under the program, to complete maternity care, application for care should be made by her or in her behalf, *as early in pregnancy as possible*, directly to the State or local health agency on forms provided for the purpose, or, in an emergency, by letter or telephone.
2. **Infant care:** Similarly, application for care of the infant should be made by the mother, or other person in behalf of the infant, directly to the State or local health agency, as soon as medical care is needed, preferably at the first visit to physician, clinic, or hospital.

NOTE.—On receipt of the application, whether complete or incomplete, the State or local health agency should assume responsibility for planning for local services and care as needed by the applicant.

DISCUSSION

The emergency maternity and infant care program is not simply the payment for services needed, but a plan whereby the State and local health agencies assist the families of enlisted men in obtaining the medical, nursing, hospital, and other services needed for maternity care of their wives and medical care of their infants, seeking the support of all community resources in meeting these needs and maintaining the highest possible standards of care. Many of these families are unfamiliar with the

² Application blanks and full information about the program should be readily available in physicians' offices, clinics, hospitals, Red Cross chapters, local health and welfare agencies, and from local public-health nurses.

Application blanks have two parts: (1) The wife's statement and (2) the physician's statement. On obtaining a blank the wife should fill out her part, take it to a physician (in office or clinic), and ask him to fill out his part. *She should then send it herself immediately to the State or local health agency.* The date when the application, including the physician's statement, is received at the State or local health agency is important in establishing the date when the cost of care is assumed by the State health agency.

However, even though prompt completion of the application is important, the wife should not delay sending in her part of the application if, for some reason, the physician's statement cannot be filled out at once or other information cannot be obtained. In this case a second application blank must be used by the physician when he fills out his request for authorization.

resources for health and other services in the community in which they are now residing. The earlier the State and local health agencies are aware of the needs of each of these families, the better they can assist them in obtaining services needed. Early application for maternity care is therefore desirable, and every possible means should be used to inform the public about the program and to encourage wives and physicians to get applications in early.

B. AUTHORIZATION FOR CARE.

1. *Maternity care:* The wife should enter on the application form the date during pregnancy when she first requested care under the emergency maternity and infant care program from this physician, clinic, or hospital.

The physician's statement on the application blank constitutes a request for authorization for the care outlined by him on the blank. Whenever possible the blank should be filled in and dated at the visit when the wife first applies to him for care under the program. The physician should check, if possible, the husband's serial number and military rank or rating, as entered on the patient's part of the form with her allowance card, letter, or other information.

The wife should be responsible for sending the completed blank to the State or local health agency.

The *effective date of authorization* (the date from which the State health agency assumes responsibility for payment for services) shall be: The date during pregnancy when the wife first requested care under the emergency maternity and infant care program from physician, clinic, or hospital, *provided* the application, signed by the physician, is received by the State or local health agency within 6 weeks after the date when the wife first requested care under the program. If this application is not received within 6 weeks after the wife first requested care under the program, the "effective date of authorization" shall be a date not more than 6 weeks prior to the date when the application, signed by the physician, was received in the State or local health agency.

In cases where the wife has made one or more visits to the physician, clinic, or hospital before she requests care under the program, and the application, signed by the physician, is received by the State health agency late in the wife's pregnancy, the *effective date of authorization* may be an earlier date than above defined, to cover previous visits, *provided* a statement is submitted to the State or local health agency in writing that (1) establishes an acceptable reason for delay in application, such as misinformation, misunderstanding of procedure, or other valid reason, (2) indicates the amount of care previously given,

and (3) shows that no payment has been made to the physician by or in behalf of the wife for care during the period covered by the authorization.

Application for delivery care received after the date of delivery should be approved for authorization *only* when supported by information indicating a medical emergency, such as a premature delivery, or a situation beyond the control of the patient, such as delay in mails, misunderstanding of procedures, misinformation, or other valid reason.

2. *Infant care:* The physician's statement on the application blank constitutes his request for authorization to give care to the infant as outlined by him on the blank. The blank should be filled in and dated during, or as soon as possible after, the first visit of, or to, a sick infant. The physician should check, if possible, the father's serial number and military rank or rating, as entered on the mother's part of the form, with her allowance card, letter, or other information.

The mother, or other person applying in behalf of the infant, should be responsible for sending the completed blank to the State or local health agency.

The *effective date of authorization* for medical care of a sick infant shall be the date when the physician or clinic or hospital agreed to give care for the present illness, *provided* it is not more than 10 days prior to the date when the application was received in the State or local health agency.

3. *Emergency care:* In case of emergency, authorization for care of wife or infant may be given, *provided* request for authorization of such services is received by letter, telephone, or telegraph within a reasonable interval of time, as defined by the State health agency, after the occurrence of the emergency.

IV. Services That May Be Authorized by State or Local Health Agencies and Rates of Payment.

A. FOR THE WIFE.

1. *Medical and surgical services provided by physicians in private practice:*³ This includes services to a patient who has sought and received care in the private office of a physician during the prenatal period. For this type of

³ For services of consulting specialists see section IV-C, item 1, p. 12.

care payment is to be made by the State health agency, directly to the physician.

It also covers services to a patient who has sought and received care in the private practice of a physician employed full time or part time by a medical school, for which payment may be made to the medical school or to the physician, depending on the customary procedure for receipt of such payments.

a. Complete maternity care: For "complete maternity care," that is, all services rendered by the attending physician (1) to the mother during pregnancy, labor, and the postpartum period from the effective date of authorization until 6 weeks after termination of pregnancy, including office treatment of intercurrent conditions whether attributable to pregnancy or not, but excluding home or hospital care of conditions not attributable to pregnancy (as outlined under *b* and *c* below), and (2) to the infant during the first 2 weeks of life: The rate of payment as established by the State health agency, but not to exceed \$50.

When fewer than seven prenatal examinations are made, when no postpartum examination is made, or when other services recognized as part of routine complete maternity care are omitted, the rate of payment for complete maternity care is to be adjusted to cover only the services actually rendered. When an obstetrician refers an infant to a pediatrician for routine care during the first 2 weeks of life, no reduction need be made in the rate of payment to the obstetrician for "complete maternity care."

In exceptional cases additional payments for attending physicians' services may be authorized by the State or local health agency for continuing care of the mother beyond 6 weeks postpartum, for a serious, acute complication resulting from pregnancy, such as puerperal infection.

(For rates of payment, see *item c* below.)

b. Major nonobstetric intercurrent surgical operations: Additional payments may be authorized by the State or local health agency to attending physicians who qualify as consultants (for qualifications of consultants see section V-B) in a surgical specialty, for major, nonobstetric surgical operations needed during preg-

nancy and 6 weeks postpartum for *conditions not attributable to pregnancy* (such as appendectomy during pregnancy): At a rate established by the State health agency but not to exceed a total of \$50 for pre-operative, operative, and post-operative care.

- c. **Medical care of other intercurrent nonobstetric conditions:** Additional payments for attending physicians' services (for a period of 3 weeks, with review by the State or local health agency before authorizing an extension of care) may be authorized by the State or local health agency during pregnancy and 6 weeks postpartum for the *home or hospital* treatment of *intercurrent conditions not attributable to pregnancy*, which do not require major surgery: At weekly rates of payment for medical care as established by the State health agency, but not to exceed \$12 for the first week of illness, and, if fewer than four home or hospital visits are made during the week, proportionate payment to be made for services rendered. For succeeding weeks of illness, a rate of payment not to exceed \$6 a week, and, if fewer than three home or hospital visits are made during a week, proportionate payment to be made for services rendered.
- d. **Prenatal care only, or spontaneous abortion:** When only prenatal care is provided by the attending physician: At a rate of payment established by the State health agency but not to exceed \$15 for care during the prenatal period. If fewer than seven prenatal examinations are made, proportionate payment to be made for services rendered.
If pregnancy terminates in spontaneous abortion not requiring an operation: At a rate of payment not to exceed \$15, plus proportionate payment for prenatal examinations made.
- e. **Therapeutic abortions:** For therapeutic abortions or spontaneous abortions requiring an operation, including pre-operative and post-operative care, the rate of payment will not exceed that established by the State health agency for care during labor and 6 weeks postpartum.
- f. **Ectopic pregnancy:** For treatment of ectopic pregnancy, including pre-operative and post-operative care when laparotomy is performed by attending physician: Rate

of payment will not exceed the rate established by the State health agency for "complete maternity care."

g. Care of newborn infant by pediatrician: Routine care of newborn infant for first 2 weeks by a qualified pediatrician (see section V-C, p. 15) when infant is referred by obstetrician who does not customarily provide routine care for infants: At a rate established by the State health agency but not to exceed \$6 a week. If fewer than three visits a week to the infant are made by the pediatrician, proportionate payment to be made for services rendered.

2. Hospital care during pregnancy, labor, or within 6 weeks after termination of pregnancy: Authorization may be made for a maximum of 14 days (with extension of care authorized, when necessary, for 2-week periods, after review by the State or local health agency) with payment at the "per diem rate" established for payments to the hospital by the State health agency times the number of days' stay in the hospital, in accordance with the Children's Bureau memorandum of September 1, 1943, Purchase of Hospital Care Under Programs for Maternal and Child Health and Crippled Children.

3. Medical and surgical services provided through clinics⁴ and hospitals: When a patient has sought and received care in a clinic or hospital, the payments to the clinic or hospital will cover payment of the cost (including maintenance and salaries) of all medical services provided by interns, residents, or other physicians employed part time or full time by the clinic or hospital and by the physicians supervising or assisting the interns or resident physicians, as well as payment for all other services provided by the clinic or hospital, as follows:

a. For clinic services (other than State or local health-agency clinics): At rates not to exceed the cost per clinic visit times the number of clinic visits and not to exceed the maximum rate established by the State health agency.

b. For hospital services: The "per diem rate" established for payments to the hospital by the State health agency times the number of days' stay in the

⁴ No authorization would be issued, nor payments made, for prenatal care given in prenatal clinics conducted by State or local public-health agencies. However, authorization for hospital care planned for through such a clinic would be necessary and should be requested by the physician in the clinic.

hospital, in accordance with the Children's Bureau memorandum of September 1, 1943, Purchase of Hospital Care Under Programs for Maternal and Child Health and Crippled Children.

c. **For clinic and hospital service:** Many hospitals have an inclusive flat rate covering out-patient and in-patient medical and hospital maternity care. This flat rate may be paid if it does not exceed the total of *a* and *b* above.

B. FOR THE INFANT.

1. ***Medical and surgical services for sick infants provided by physicians in private practice:***⁵ This includes care that has been sought on behalf of, and received by, a sick infant in the private practice of a physician (home, hospital, or office) during the infant's first year of life. For this type of care payment is to be made directly by the State health agency to the physician. It also covers care sought on behalf of, and received by, a sick infant in the private practice of a physician employed full time or part time by a medical school, payments for which may be made to the medical school or to the physician, depending on the customary procedure for the receipt of such payments.

Medical care may be authorized for a period not to exceed 3 weeks, with review by the State health agency before authorizing extension of care.

a. **Medical care, including minor surgery:** At weekly rates established by the State health agency but not to exceed \$12 for the first week of illness, and, if fewer than four visits for examination or treatment are made during the week, proportionate payment to be made for services rendered. For succeeding weeks of illness, \$6, and, if fewer than three visits for examination or treatment are made in any week, proportionate payment to be made for services rendered.

b. **Major surgery:** Additional payments may be authorized by the State health agency to attending physicians who qualify as consultants (for qualifications for consultants see section V-B) in a surgical specialty, for

⁵ For services of consulting specialists see section IV-C, item 1, 12. .

major surgical operations performed on infants under their care (exclusive of care for which infants are eligible under State crippled children's programs): At rates of payment to be established by the State health agency but not to exceed a total of \$50 for pre-operative, operative, and post-operative care.

2. **Hospital care:** Hospital care during the first year of life may be authorized for 14 days (with extension of care authorized, when necessary, for 2-week periods after review of case by State or local health agency): At the "per diem rate" established for payments to the hospital by the State health agency times the number of days' stay in the hospital, in accordance with the Children's Bureau memorandum of September 1, 1943, Purchase of Hospital Care Under Programs for Maternal and Child Health and Crippled Children.
3. **Medical and surgical services provided through clinics and hospitals:** When care of a sick infant has been sought and received in a hospital or clinic, the payments to the clinic or hospital will cover payment of the cost (including maintenance and salaries) of all medical services provided by interns, residents, and other physicians employed part time or full time by the clinic or hospital and by physicians supervising or assisting interns or resident physicians, as well as payment for all other services provided by the clinic or hospital, as follows:
 - a. **For clinic services:** At a rate not to exceed the cost per clinic visit times the number of clinic visits and not to exceed the maximum rate established by the State health agency.
 - b. **For hospital services:** The "per diem rate" established for payments to the hospital by the State health agency times the number of days' stay in the hospital, in accordance with the Children's Bureau memorandum of September 1, 1943, Purchase of Hospital Care under Programs for Maternal and Child Health and Crippled Children.
4. **Immunizations:** In physicians' offices or at child-health conferences or immunization clinics not conducted by State or local health agencies:⁶ At rates established by

⁶ No authorization would be issued, nor payment made, for immunizations at child-health conferences or immunization clinics conducted by State or local public-health agencies.

the State health agency but not to exceed \$6 total for immunization for smallpox, diphtheria, and whooping cough (plus the cost of biologicals in States where these biologicals are not provided without cost by the State or local health agencies). These immunizations usually will require, during the first year of life, one procedure for smallpox, two or three for diphtheria, and three for whooping cough. If immunizations for all three diseases are not completed, proportionate payment to be made for services rendered.

NOTE.—Health supervision of infants.

Health supervision of infants may be arranged for in child-health conferences made available by State or local health agencies or by voluntary health agencies. For the present the cost of health supervision through conferences may be met from maternal and child-health funds made available under title V, part 1, of the Social Security Act.

Administrative problems relative to the inclusion under the emergency maternity and infant care program of health supervision of infants in physicians' offices are now being studied by the Children's Bureau and will be reviewed in the near future with State and local officials responsible for the administration of the program. These problems include the desirable minimum requirements of training and experience to be established for physicians providing health supervision of infants and the methods of authorizing and making payments for such supervision provided in physicians' offices. When decisions with respect to payment for health supervision of infants are reached, a supplement to this statement of policy will be issued.

It is recommended, therefore, that authorization for health supervision of infants, except for immunizations, not be given under the emergency maternity and infant care program until the Children's Bureau policy on these matters has been made available to State administrative agencies.

C. FOR THE WIFE OR INFANT.

- 1. *Consultation services requested by attending physician*** (from consultants on list approved by the State health agency):
 - a. Long distance telephone consultation:** The actual cost of the call.
 - b. Bedside consultation or assistance, or minor surgery:** At the rate of payment established by the State health agency but not to exceed \$10 per consultation.
 - c. Consultation which includes performance of a major surgical operation by the consultant and for the pre- and post-operative care provided by the consultant:** At the rate of payment established by the State health agency but not to exceed \$50.

2. ***Bedside nursing service in home or hospital, when requested by attending physician:***
 - a. ***In a hospital by graduate nurses:*** Special nursing services during a period of critical illness when such nursing services cannot be provided by nurses employed by the hospital and when no expenditures for special nursing service have been included in the hospital's annual statement of operating expense may be authorized for a period not to exceed 4 days, with review by State or local health agency before authorizing extension of care, at prevailing local hourly or per diem rates not to exceed maximum rate established by State health agency.
 - b. ***In the home by nursing staff of a voluntary public-health or visiting-nurse agency or by graduate nurses*** (when such nursing services cannot be made available by State or local public-health agencies):
 - (1) Visits for care of mother and infant while the mother is receiving bed care during the puerperium may be authorized not to exceed 6 visits, with review by the State health agency before authorizing extension of care, at prevailing local rates per visit but not to exceed the maximum rate established by the State health agency.
 - (2) Visits for care of a sick mother or infant may be authorized not to exceed 14 visits, with review by the State health agency before authorizing extension of care, at prevailing local rates per visit but not to exceed the maximum rate established by the State health agency.
 - (3) Nursing care throughout the period of labor and delivery may be authorized at prevailing local rates but not to exceed the maximum rate established by the State health agency.
 - (4) Special nursing services on an hourly or per diem basis during a period of critical illness may be authorized for a period not to exceed 4 days, with review by the State health agency before authorizing extension of care, at prevailing local rates but not to exceed the maximum rate established by the State health agency.

- (5) Visits for care of a patient who has complications, in order to carry out specific orders by the physician, such as determining blood pressure, urinalysis, or giving special treatments or medications, may be authorized not to exceed 6 visits, at prevailing local rates per visit but not to exceed the maximum rate established by the State health agency.
3. **Blood for transfusions:** May be authorized at the customary minimum rate paid by the hospital but not to exceed the maximum rate established by the State health agency.
4. **Ambulance service:** When requested by attending physician or hospital, ambulance service may be authorized at prevailing local rates but not to exceed the maximum rate established by the State health agency.
5. **Additional payment for time in travel and for cost of travel to attending physician or consultant:** May be authorized for attending seriously ill patients or for home deliveries outside of city limits of physician's residence, at rates established by the State health agency but not to exceed 25 cents per mile each way traveled outside of the city limits, with a maximum payment of \$25 to a physician for travel for any one case.
6. **Additional payment for cost of travel of graduate nurse** not employed by a public or voluntary health agency to the home of a patient may be allowed at the cost of transportation outside of city limits on a public carrier or at the usual rate for mileage established for State employees.

DISCUSSION

The appropriation act for emergency maternity and infant care states that the funds are to be used to provide medical, nursing, and hospital maternity and infant care. Review of the discussions in Congress clearly indicates that it has been the intent of Congress to provide as complete and as satisfactory medical, nursing, and hospital care during the maternity period and the first year of the infant's life as is possible to obtain. To supplement when necessary the care usually recognized as required for the uncomplicated maternity case or for the sick infant, special additional care needed for complications or serious illness is therefore included under the program. This includes, as necessary, consultation and diagnostic assistance of specialists, which should be made as freely available as possible under the program; prolonged hospital care, special nursing service, and special therapeutic measures such as blood for transfusion when applied for by the attending physician, clinic, or hospital during the period when care has been authorized.

Calling a consultant should not affect the rate of payment to the attending physician if he continues to provide care to the patient.

V. Qualifications for Physicians and Nurses Participating in the Program.**A. FOR OBSTETRIC SERVICES.**

Qualifications required of practitioners performing obstetric services under the program shall be established by each State health agency.

B. FOR MEDICAL SERVICES OTHER THAN OBSTETRIC.

Graduates of medical schools approved (at time of graduation or subsequent to graduation) by the Council on Medical Education and Hospitals of the American Medical Association. Individual exceptions may be made when a person with the degree of Doctor of Medicine who is not a graduate of a medical school approved (at time of graduation or subsequent to graduation) by the Council on Medical Education and Hospitals of the American Medical Association has completed postgraduate training which, in the opinion of the State health officer and his technical advisory committee, makes him competent to participate in this program.

Additional qualifications for consultants: Specialists who are certified by their respective American boards of medical specialties, or whose training and experience meet the requirements of training and experience for admission to the examinations of such boards, should be designated as consultants by the State health departments and, whenever possible, made available for bedside consultation (or telephone consultation when bedside consultation is not feasible) with physicians participating in the plan. Physicians who have had at least 1 year of graduate training in a residency in their specialty approved by the Council on Medical Education and Hospitals of the American Medical Association and at least 1 year's experience limited to the practice of the specialty may be designated as assistant consultants.

For areas where consultants with the training and experience as set forth in the above paragraph are not available, a State technical advisory committee, appointed by the State health agency for this program, should recommend to the State health agency a plan for providing consultation to patients living in such areas.

Lists of physicians approved by the State health agency as consultants in the various specialties should be made available to all physicians participating in the program.

C. FOR PEDIATRIC SERVICES TO NEWBORN INFANTS REFERRED BY OBSTETRICIANS.

Diplomates of the American Board of Pediatrics or physicians who have completed at least 1 year of graduate training

in a pediatric residency approved by the Council on Medical Education and Hospitals of the American Medical Association.

D. FOR NURSING SERVICE PURCHASED ON A CASE BASIS.

Graduate nurses registered or eligible for registration by meeting requirements of the State board of nurse examiners and having had training and experience in maternity and/or pediatric nursing as required by the State health agency.

VI. Minimum Requirements for Hospitals Participating in the Program.

The following represent minimum requirements that will be used by the Children's Bureau in reviewing State plans for approval. A State health department may use them as a basis for preliminary approval of hospitals for obstetric care, but they should not be construed as establishing even minimum *standards* for such hospitals.

Since in the various States wide differences will be found in hospital facilities available, some State health departments will be able to establish higher requirements than others. Each should develop a set of requirements that are as high as are practicable under existing conditions, and should consider the possibility of raising the requirements as soon as possible.

Since in some States it will be practicable to establish minimum requirements that could not be met by many of the hospitals in other States, those requirements which should be considered absolutely minimum for emergency approval under any conditions have been indicated by one star (*), and those which should be established as minimum when conditions permit, either at the time of approval or later, have been indicated by two stars (**).

A. BUILDINGS

*Obstetric care shall be authorized only in buildings that meet State or local rules and regulations for fire protection and sanitation.

*Buildings shall be adequately screened to give protection against flies and mosquitoes.

*Every room in which maternity patients or newborn infants are cared for shall have at least one window to provide light and ventilation (unless forced ventilation is provided).

There is evidence that sunlight passing through ordinary window glass has some bactericidal action. Change of air content of rooms by admitting outdoor air tends to reduce the bacterial content of the air and adds to the patient's comfort.

*In every room used in the care of maternity patients and newborn infants there shall be artificial lighting adequate for the purposes for which the room is used.

*There shall be provision for adequately heating the building in cold weather, with maintenance of a fairly uniform temperature in delivery rooms and nurseries.

The shock of labor and delivery for mother and infant makes provision of suitable environmental conditions essential. The newborn infant's need for artificial heat after leaving the protection of the uterus is obvious, and chilling may be fatal, especially to premature infants.

B. MATERNITY UNIT.

*Maternity patients and newborn infants shall be cared for only in wards or rooms completely separated from other wards or rooms in which patients with communicable diseases or septic conditions are cared for.

The special susceptibility of parturient women and newborn infants to various types of infection is well known. The danger of cross-infection will be less the greater the degree of separation of these patients from all other patients, that is, in a separate wing, a separate floor, or a room or rooms separated by a partition from that section of the hospital in which patients with septic conditions or communicable diseases are cared for.

**Maternity patients shall be cared for only in a part of the hospital in which complete separation from all other patients is possible.

1. Facilities for delivery.

*If there is no delivery room separate from the general operating room, patients shall be delivered in their own rooms, except in case of Cesarean section. There shall be conveniently located facilities for the attendants at delivery to scrub their hands.

Since the parturient woman is especially susceptible to infection, it is unwise to deliver her in a room used for septic cases regardless of the care with which cleaning of the room is carried out. Hand-scrubbing facilities are essential to the use of aseptic technique.

**There shall be a properly equipped delivery room used exclusively for the delivery of noninfectious patients. There shall be running water in this room or adjacent to it.

*There shall be suitable facilities for administering general anesthesia.

*There shall be suitable apparatus for administering oxygen to infants.

*A reliable method of identifying each infant shall be applied in the delivery room.

2. Nursing services.

*A graduate registered nurse shall be responsible at all times for nursing care of both maternity patients and newborn infants.

**At least one graduate registered nurse shall be on duty at all times to supervise the care of both maternity patients and newborn infants.

Every parturient woman and newborn infant needs skilled nursing care. This is essential not only for the normal needs, but because of the potential danger to both from infection and hemorrhage, and the danger to the infant from asphyxiation.

In addition, the nurse is the person who is responsible throughout the 24 hours and will often be required to make decisions vital to the patients' safety (both mother and infant) in the absence of the physician.

3. Care of utensils and linen.

*There shall be facilities for disinfection or, preferably, sterilization of bedpans.

Contaminated bedpans may be a source of cross-infection.

*There shall be adequate and suitable receptacles for soiled linen (bed linen, gowns, and diapers).

Soiled linen, if not kept in closed containers, may be a source for spread of infection.

**There shall be a utility room used for maternity patients only.

4. Laboratory and clinical facilities.

*There shall be facilities *in the hospital, or available in the community*, for laboratory examinations, including blood counting, hemoglobin determinations, and urinalyses.

**A separate room shall be provided in the hospital for a laboratory.

*There shall be facilities in the hospital always ready for intravenous therapy.

**There shall be serum available in the hospital for blood-matching for transfusions.

*The hospital shall provide adequate facilities for sterilization of equipment, supplies, and instruments.

5. Records.

*A clinical record shall be kept for each patient, mother and infant separately.

6. Accommodations for patients.

a. For the mothers.

*Rooms or wards in which maternity patients are cared for shall provide average space equal to at least 60 square feet per patient.

To provide for adequate ventilation, for space for bedside care of the patient, and for separation of the patients sufficient to minimize respiratory cross-infections.

**Rooms or wards in which maternity patients are cared for shall provide average space equal to at least 80 square feet per patient.

*There shall be a separate bed for each patient.

**There shall be a separate thermometer and a bedpan for each patient.

(1) Hand-washing facilities.

*Running water shall be conveniently available to every room in which maternity patients are cared for.

To facilitate hand washing by staff (medical and nursing) before and after caring for each patient. Hand washing is one of the important measures for prevention of infection. The more convenient the facility the more likely it is that the hand scrubbing will be done.

**Running water shall be available in each room or ward.

(2) Isolation facilities.

*A room shall be available at all times in which a maternity patient who has an infection may be isolated.

Prevention of spread of infection from one patient to another depends upon separation of the patient who is suspected of having an infection from non-infected patients and upon maintaining rigid separate isolation of the infected patient until cured or, preferably, until discharged from the hospital.

**Space shall be available at all times for isolation of at least one patient for every 25 obstetric beds or fraction thereof.

(3) *Dietary department.*

*Food adequate for the needs of the parturient women shall be prepared and served under sanitary conditions.

**If the food service is not under the direction of a qualified dietitian, consultation should be obtained from a dietitian or nutritionist available to the community.

b. For the infants.

(1) *Nursery facilities.*

*If newborn infants are not kept in their mothers' rooms, a separate nursery shall be provided for them, which is used for no purpose other than the care of such infants.

*Provision shall be made to exclude visitors from contact with infants. If infants are kept in their mothers' rooms a separate room must be made available in which to place them during visiting hours.

To prevent respiratory infections in newborn infants they should be isolated from visitors.

*Each infant shall have a separate bassinet.

In order to minimize the danger of cross-infection, two infants should never occupy the same bassinet, even if they are twins.

*Individual bassinets shall be separated by at least 6 inches.

Separation of bassinets is required (1) so that bedclothes from one bassinet will be less likely to come in contact with those on either side and (2) to facilitate bedside care of each infant.

**Individual bassinets shall be separated by at least 12 inches.

*Nurseries shall be large enough to provide an average of at least 16 square feet of floor space per infant.

This is the minimum space that will permit proper spacing of beds (6 inches from walls and 6 inches

between beds) and that will provide space for the nurse to care for the infant.

**Nurseries shall be large enough to provide an average of at least 20 square feet of floor space per infant.

*There shall be provided for premature infants at least 1 incubator or some type of heated bed for each 20 bassinets for full-term infants, or any fraction thereof.

*There shall be provided in the nursery facilities for washing or disinfecting the hands.

To avoid carrying infection to infants the hands must be carefully washed both before and after caring for each infant.

(2). *Isolation for infants.*

*There shall always be available a room in which infants who have or who are suspected of having infections may be strictly isolated from the well infants and from each other.

To prevent spread of infection, there should be provision for immediate isolation of any infants suspected of having an infection.

(3). *Clinical facilities for infants.*

*There shall always be available facilities for oxygen administration suitable for use with infants.

Newborn infants, especially premature infants, are prone to respiratory difficulties. Oxygen administration is essential for combating these difficulties.

*There shall always be available either in the hospital or in the community sterile sets for intravenous or subcutaneous administration of blood or other fluid to infants.

(4). *Facilities for preparation of milk mixtures.*

*There shall be suitable space and adequate equipment for preparation of milk mixtures (formulas) and for their sterilization and refrigeration.

**There shall be a separate room used exclusively for the preparation of sterile milk mixtures.

[[PUBLIC LAW 156—78TH CONGRESS]]

[[CHAPTER 253—1ST SESSION]]

[[H. J. Res. 159]]

JOINT RESOLUTION

Making additional appropriations for the fiscal year 1944 for emergency maternity and infant care for wives of enlisted men in the armed forces.

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending June 30, 1944, under the Children's Bureau, Department of Labor, namely:

Grants to States for emergency maternity and infant care (national defense): For an additional amount for grants to States, including Alaska, Hawaii, Puerto Rico, and the District of Columbia, to provide, in addition to similar services otherwise available, medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men of the fourth, fifth, sixth, and seventh grades in the armed forces of the United States, under allotments by the Secretary of Labor and plans developed and administered by State health agencies and approved by the Chief of the Children's Bureau, \$18,600,000: *Provided*, That this appropriation may be used for payments of commitments made prior to October 1, 1943, in the cases of wives and infants of enlisted men in grades one, two, and three.

Salaries and expenses, emergency maternity and infant care (national defense): For all necessary expenses of the Children's Bureau in performing the duties imposed upon it in carrying out the program for emergency maternity and infant care, including personal services in the District of Columbia and elsewhere, and other items otherwise chargeable to the appropriations of the Department of Labor for contingent expenses, traveling expenses, and printing and binding, \$20,000.

Approved October 1, 1943.

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